Utilizing the Section 1115 HIFA Waiver Option to Improve Services for Persons with Mental Illness

The President's New Freedom Initiative is a comprehensive plan to remove barriers to community living for people with disabilities by working to ensure that all Americans have the opportunity to learn and develop skills, engage in work, make choices about their daily lives and participate fully in community life. The information in this paper supports this initiative by describing how a state might use the Health Insurance Flexibility and Accountability (HIFA) waiver option under Section 1115 authority to improve access to community-based services for persons with mental illness. These services can include basic health care coverage, enhanced community-based supports, and provisions to encourage the use of employer-sponsored insurance (ESI). States may include groups of individuals with a mental illness who meet specific diagnostic or program participation criteria. Disproportionate Share (DSH) funds that currently support psychiatric institutional services can be used to support a HIFA waiver program.

Background

Section 1115 of the Social Security Act gives the Secretary of the Department of Health and Human Services (DHHS) broad flexibility to allow states to implement demonstration programs of national significance. The HIFA option under that authority is specifically designed to help states to extend coverage to uninsured individuals. This option is intended to:

- Encourage innovation to improve how Medicaid and State Children's Health Insurance Program (SCHIP) funds are used to increase health insurance coverage for low-income individuals; and
- Give states the programmatic flexibility required to support approaches that increase private health insurance coverage options.

In addition, the HIFA waiver was designed to provide for a streamlined application and approval process and to afford states specific flexibility in the benefit design and cost sharing components of an expansion program.

To use a HIFA waiver, a state must agree to certain program and funding requirements. A HIFA waiver must:

- Be in effect statewide (although geographic phase-in can be authorized);
- Expand coverage to previously uncovered persons;
- Coordinate or encourage private (especially ESI) and public health insurance coverage for low-income uninsured persons through approaches such as premium assistance and wraparound services;
- Continue to provide the services specified in a state's Medicaid Plan to mandatory populations, such as recipients of cash assistance through the Temporary Assistance to Needy Families (TANF) and Supplemental Security Income (SSI) programs;
- In states using SCHIP funds, maintain Medicaid eligibility levels for children that are no more restrictive than were in effect in June 1997;

- Not cover adults in the demonstration at higher income levels than children in SCHIP;
- Provide specific services to optional populations,[1] including hospital and physician services;
- Provide a basic primary care benefit to expansion populations[2] but may limit the types of providers and types of services and employ cost sharing provisions; and
- Be budget neutral under Medicaid or allotment neutral under SCHIP.

Each HIFA waiver operates under a financial agreement that limits federal financial payments over the life of the demonstration and this limit is negotiated prior to approval of the waiver. A demonstration that uses Medicaid funding must be budget neutral. The budget neutrality agreement includes a provision for expected cost inflation over the five-year waiver period. HIFA waivers can be funded by savings resulting from service reductions or eligibility changes, by redirecting existing Disproportionate Share Hospital (DSH) funds and/or by using unexpended federal DSH or SCHIP funds. A demonstration that uses SCHIP funding must show that the funding for the SCHIP state plan and the demonstration do not exceed the state's available SCHIP allotment for each year ("allotment neutrality").

HIFA Waiver Activity

Ten HIFA waivers have been approved as of February 2005 in the states of Arizona, California, Colorado, Idaho, Illinois, Maine, Michigan, New Mexico, New Jersey and Oregon. All of these waivers extend health care coverage to previously uncovered individuals, although none of these waivers target persons with mental illness who are uninsured. Four HIFA waivers include previously state-funded programs (AZ, IL, MI and OR) and one includes unspent DSH funds (ME).

Expansions of eligibility are a primary objective of the HIFA waiver option. While most expansions approved to date have been targeted to broad eligibility groups, such as parents of minor children with incomes up to 200 percent of the FPL (AZ, CA and NM) or childless adults with incomes up to 100 percent of the FPL (AZ and ME), more "targeted" expansion populations have been authorized.

Illinois received authorization to include persons with incomes up to 185 percent of the FPL who are eligible for the state's risk pool (i.e. uninsurable individuals) or for the state's hemophilia program. When Illinois submitted its HIFA Waiver application, it included three state-funded programs: the state's risk pool, a hemophilia program and an end-stage renal disease (ESRD) program. The ESRD program was not authorized because basic primary care services were not included for the ESRD expansion population. However, Illinois agreed to provide primary care services for persons enrolled in the hemophilia program consisting of physician services. Other health care services such as prescribed drugs or inpatient hospital services are limited to hemophilia-related care.

Arizona and Michigan included a previously state-funded uninsured coverage program in their HIFA waiver. Michigan's coverage for the expansion population included enhanced access to mental health services for consumers with less "urgent" mental health needs. These persons

previously accessed mental health services only when other persons with more urgent mental health needs had been served first and only if funding remained available.

Coordination of public and private health care benefits, especially coordination with ESI, is another primary objective of a HIFA waiver. States have used the HIFA waiver vehicle to provide an option for Medicaid recipients to choose between Medicaid and ESI (IL) or to incorporate an ESI component into the Medicaid program (NM.)

New Mexico was authorized to contract with managed care organizations to provide a health insurance benefit package that is less comprehensive than the Medicaid benefit package to employed residents with incomes up to 200 percent of the FPL, including childless adults. The health insurance benefit is purchased with state, federal, employer, and employee contributions. As of March 2005, the New Mexico HIFA Waiver had not yet been implemented.

Coordination with ESI can also include assistance with co-pays and deductibles, and access to wrap-around services not included in the ESI benefit package. If a state proposes a limited benefit package for an expansion population, the package must contain a basic primary care health benefit consisting of, at a minimum, health care services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician.

Persons with Mental Illness and Medicaid Eligibility

In most instances, persons with a mental illness are determined Medicaid eligible either because they are poor and the head of a household with minor children or because they meet disability requirements and either have been determined by the Social Security Administration to qualify for SSI or otherwise meet the income qualifications for a state's Medicaid program. According to the *SSI Annual Statistical Report 2001*, prepared by the Social Security Administration, mental illness was the most common diagnosis among SSI recipients under the age of 65, accounting for 36 percent of all SSI recipients in this age group. SSI recipients are automatically eligible for Medicaid in most states.[3]

Even when a person with a mental illness has access to Medicaid, they may face periods of lost coverage as a result of earned income or as a result of the loss of disability status when symptoms related to an illness stabilize and the person is able to regain functioning in daily living and social skills. Likewise, persons who receive Social Security Disability Income (SSDI) who are not SSI eligible, face periods of uninsurance or limited coverage. According to the *Annual Statistical Report on the Social Security Disability Insurance Program, 2002*, 26.2 percent of all individuals on SSDI (or 1,701,328 persons) have a mental illness.[4] SSDI recipients may experience loss of coverage when they:

- Are in their two-year waiting period for Medicare benefits; or
- Receive Medicare Part A but are ineligible, based on income, for Medicaid assistance with Medicare Part B cost sharing requirements; or
- Lose SSDI and related Medicare benefits as a result of earned income.

Continued employment may be difficult when the person must secure another source of health insurance. Individual policies may be unaffordable, limited in scope or may contain pre-

existing condition limitations that result in coverage that is less than comprehensive. ESI, when available, may present similar barriers.

Improving Access to Health Care for Persons with a Mental Illness

The HIFA waiver authority offers several features that assist in addressing the health care coverage needs of persons with a mental illness. HIFA waivers provide a vehicle for expansion of eligibility and services that may be targeted to a specific group, provide authority to redistribute existing Medicaid funds and to include previously state-only funds (subject to specific requirements), and specifically encourage the coordination of and utilization of ESI.

Expansion of Coverage

Illinois' inclusion of state programs in their HIFA waiver provides an example of how a state can expand access to health care services. A state that currently provides non-Medicaid health related services to individuals with a mental illness who have incomes above the state's current Medicaid eligibility limits could include this group in a HIFA waiver. Inclusion of the program in the waiver could ensure access to a basic primary care package (if not included previously) and cover additional persons at higher income levels. It could also coordinate coverage with ESI, or expand the scope of covered services specific to the needs of individuals with a mental illness.

An expansion population can be limited by diagnosis or by program component. For example, Illinois included individuals with hemophilia with higher incomes who were enrolled in a state-funded hemophilia program and individuals enrolled in the state's risk pool. Similarly, a state could include individuals enrolled in a state program serving individuals with a specific mental illness who would otherwise be uninsured and who would not have access to essential health care services, including mental health services. The unique needs of an expansion population should be considered when developing a basic primary care package. For persons with serious mental illness, states should consider how psychiatric services and appropriate prescribed drugs are covered either through the waiver or through another funding source.

The state must meet maintenance of effort requirements when utilizing previously unmatched state funds. These are generally applied by calculating the amount the state would have spent over the life of the waiver had the state made expenditures at the level expended during the state fiscal year prior to implementation of the waiver.

Redirection of Disproportionate Share Hospital (DSH) Funds

DSH funds have been utilized to fund coverage expansions in the past, both through the use of a traditional 1115 waiver and through a HIFA waiver. Utilization of DSH funds includes either redirection of these funds or utilization of a state's unspent DSH allotment. DSH funds are an important revenue source for many state-operated psychiatric hospitals, although recent changes in federal law have reduced the amount a state may allocate to such facilities. Nevertheless, states could use DSH funds to support their objectives under a HIFA waiver.

The use of DSH funds allows an opportunity for states to expand access to a basic primary care benefit and an array of community-based services for individuals who have incomes higher than a state's current eligibility limit. As noted previously, the unique needs of an expansion population should be accounted for when developing a basic primary care package.

Maine's approach to the use of DSH funds is unique in using unspent DSH funds, rather than redirecting existing funds. Utilization of unspent DSH allotments avoids impacting existing hospitals participating in the DSH program. To ensure budget neutrality when using unspent DSH allotments, states must ensure that costs under the demonstration will be limited to an amount that, when added to total DSH payments under the state's Medicaid Plan, do not exceed the allowable aggregate DSH allotment for the state under the federal statute (calculated with the federal and state shares) for each of the five years of the demonstration. States must continue to comply with the hospital-specific limits as provided in federal law for DSH payments.

Currently, only a limited number of states have unspent DSH allotments that could be used in this fashion. However, as a result of changes in rules governing the use of DSH payments to non-IMD public hospitals, additional states may have unused DSH capacity in the near future. This capacity could be used to expand coverage to individuals with mental illness who are uninsured.

Coordination of Health Care Benefits

Coordination of public health care benefits with private coverage such as ESI through approaches such as premium assistance is a primary objective of a HIFA waiver. Therefore, a HIFA waiver proposal must address this objective and could include program components designed to support work effort and retention of ESI by persons with mental illness. Examples of program features that would serve to strengthen coordination with ESI include:

- An intensive outreach and targeted eligibility tracking mechanism that ensures that individuals with a mental illness and their families do not experience periods of uninsurance but rather can move between coverage categories with no interruption in coverage
- State coverage of premium payments or provision of Medicaid benefits during periods of non-coverage. Periods of non-coverage include instances when an individual switches jobs and does not have immediate coverage from their new employer, when an individual becomes ineligible based on age, or during other types of transitions.

In addition, States might provide wrap-around benefits to supplement ESI coverage in order to ensure access to an array of services that meets the needs of persons with mental illness. Since typical mental health coverage under ESI is more limited than that for general health care, such supplemental coverage may be essential if persons with serious mental illness are to be able to maintain employment and recovery.

Because the primary objectives for a HIFA waiver are reductions in the level of uninsurance and coordination with ESI, states must monitor and report on their progress toward reducing the rate of uninsurance throughout the waiver period. In addition, states must monitor the private insurance market especially in regard to changes in employer contribution levels and substitution of coverage. In addition, data on the HIFA populations must be separately identified in all required reporting.

Summary

Goals established by the President and objectives of CMS[5] support the timeliness of the development of HIFA waiver programs that include or specifically target persons with a mental illness. Such programs can be a valuable addition to a State's community-based service system and can help support a system of recovery-oriented services for persons with mental illness. In developing a HIFA waiver application, the State must ensure that the primary objective of the waiver, a reduction in the number of uninsured persons in the state, is achieved. If a state uses previously unmatched state funds, the state must also ensure maintenance of effort.

REFERENCES

CMS website http://www.cms.hhs.gov/hifa/default.asp. *Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative.*

CMS website http://www.cms.hhs.gov/medicaid/waivers/waivermap.asp. *State Waiver Programs and Demonstrations.*

Sachs, T. *HIFA at Age Two: Opportunities and Limitations for States*, November 2003, State Coverage Initiatives.

ENDNOTES

[1] Populations that can be covered under a Medicaid or SCHIP State Plan, such as children, pregnant women, and parents with incomes above mandatory minimum levels, low income aged, blind and disabled, and the medically needy.

[2] Populations not covered through Medicaid or SCHIP absent an 1115 waiver (e.g. childless adults).

[3] SSI Annual Statistical Report, 2001. The Social Security Administration. http://www.ssa.gov/policy/docs/statcomps/ssi_asr/2001/.

[4] Annual Statistical Report on the Social Security Disability Insurance Program, 2002. The Social Security Administration. http://www.ssa.gov/policy/docs/statcomps/di_asr/2002/table06.pdf.

[5] For more information regarding the ADA, Olmstead and Federal initiatives visit the CMS Internet site at: http://www.cms.hhs.gov/newfreedom/.